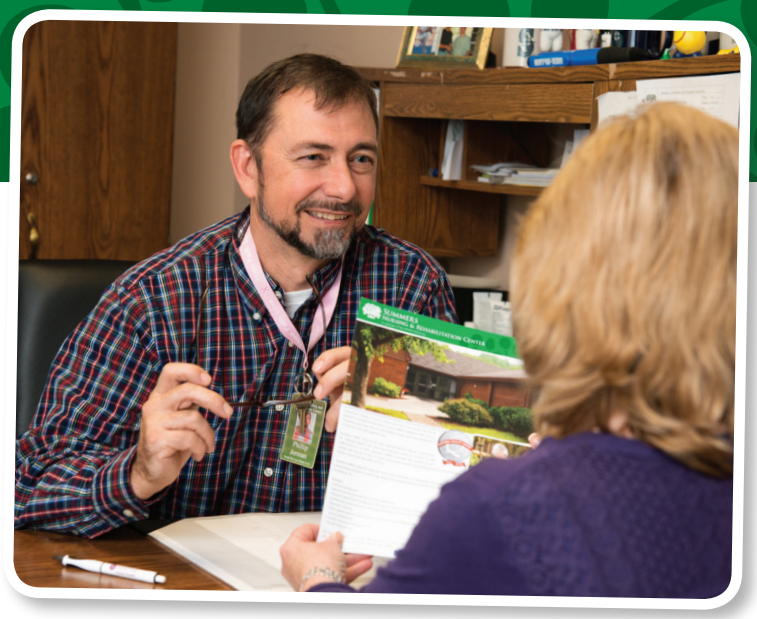
Paying for care



We understand placing a loved one somewhere other than home can be a confusing and difficult time.

Whether for short-term rehabilitation or long-term care, we strive to make the transition as easy as possible.

Below is a basic overview of payment options. For more information or questions on your individual medical or financial situation, please contact an AMFM center near you.

How can I pay for care?

Depending on your health care needs, there are multiple ways to pay for care.

Private Payment

Traditional Medicare

Medicare Advantage Plans

Medicaid

Private insurance

Private Payment

If you do not have Medicare, Medicaid or long-term care insurance, then private payment would be your option. Bills will be generated by the Business Manager (BM) on a monthly basis and are to be paid upon receipt. Upon placement, the first 30 days of care are to be paid in advance.

Traditional Medicare

Medicare is accepted for placement for those residents who qualify for the benefit and who meet the Medicare requirements for skilled services in our facility. The qualifications briefly stated are:

• *People who have had certain disabilities for more than two years.*

• *The individual must have active Medicare Part A.*

• *A three night qualifying stay as an in-patient in an acute care hospital within the last 30 days prior to admission to a nursing facility.*

• *The individual must require a daily "skilled service" while at the facility. Please visit our Social Worker for questions on "skilled services."*

The Medicare benefit covers the following:

Pays 100% of the cost of medically necessary services during the first 20 days of placement.

These services may include room and meals, routine nursing care, supplies and equipment, pharmacy services, physical therapy, speech therapy and occupational therapy.

Beginning on day 21 and up to day 100, either the individual, Medicaid, or other supplemental insurance will be responsible for paying a coinsurance portion.

Medicare Advantage Plans

Medicare Advantage Plans, sometimes referred to as HMO or PPO, are offered by private companies approved by Medicare. Medicare pays these plans to cover your Medicare benefits.

Medicare Part A entitlement may cover costs listed

above for UP to 100 days. The individual MUST require a skilled service as defined by Medicare for the entire 100 days. There is no guarantee that 100 days can be used if the resident's condition stabilizes.

Medicaid

The individual or responsible party must apply for this benefit at their local West Virginia Department of Health and Human Resources (WVDHHR). As defined by the Medicaid program, eligibility is determined on the basis of financial and medical need. This need is established by the applicant's meeting four points of eligibility:

- *Medical need.*
- *Nursing home certification.*
- *Monthly income.*
- *Countable assets.*

Medical Need is established by the individual's attending physician, who must certify the medical need and indicate that nursing home placement is needed.

Nursing Home Certification means the individual must be placed with a nursing home that is certified by the state of West Virginia. Our centers are certified by West Virginia. Medicaid payment can only be made to those certified homes electing to participate in the Medicaid program.

Monthly income is reviewed by the local Medicaid office to determine eligibility of Medicaid benefits. Specific information regarding income guidelines may be obtained by contacting your local West Virginia Department of Health & Human Services (WVDHHR) office.

Countable Assets include, but are not limited to: money in checking/savings accounts, certificates of deposit (CDs), stocks, bonds, cash-on-hand, retirement accounts such as IRA's, cash value on life insurance policies and property other than one's home. The individual's total countable assets cannot exceed $2,000 to be eligible for Medicaid. Specific questions regarding approval should be directed to your local WVDHHR office.

Private Insurance

Some private insurance companies offer a skilled nursing facility benefit. Prior to admission, and with your written permission, we will contact your insurer and ask about any skilled nursing facility benefits available through your policy.

Some private insurance plans are known as "Medigap" coverage. A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in Traditional Medicare coverage. Medigap policies help pay some of the health care costs that Traditional Medicare doesn't cover. If you have Traditional Medicare and have a Medigap policy, then Medicare and your Medigap policy will each pay its share of covered health care costs before you are billed for any covered charges.

Quality Care...today & tomorrow

1-800-348-1623